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# Pediatrics for Parents

*The newsletter for people who care for children*

Richard J. Sagall, MD, Editor

## *In this Issue...*



## Does Seeing Smoking in Movies Affect Our Youth?

A recent study conducted by a team of researchers from Dartmouth Medical School's Norris Cotton Cancer Center found that our nation's adolescents are exposed to billions of impressions of smoking in movies. Their research estimated that 534 box office hits released from 1998-2002 delivered almost 14 billion smoking impressions to 10-14 year olds.

Even though PG-13-rated movies contained fewer than 40% of smoking impressions, they delivered more than 60% of smoking impressions to 10-14 year olds because more children in that age group saw them than R-rated movies, which contained more smoking impressions but were seen by fewer 10-14 year olds. This study was the first of its kind to directly estimate U.S. adolescent exposure to smoking in movies.

## Bigger Needles Are Better

When it comes to childhood immunizations, the bigger the needle the better. That's the conclusion of an English study of 696 infants receiving routine childhood shots.

The infants were divided into three groups based on the length and gauge of the needle used. One-third of the infants received shots using a narrow, short needle (25 gauge (0.5 mm diameter), 16 mm long). The second group had narrow, long needles (25 gauge, 25 mm long) and the third group had wide, long needles (23 gauge (0.6 mm), 25 mm long). All the immunizations were given using the same technique.

The researchers considered two factors: immune response and reactions to the shot. All the infants had blood tests 28-42 days after the shots to determine their immune response. All developed a good immune response regardless of which needle was used, although the wide, long needle group had slightly higher response levels.

Parents reported the children's immediate reactions and also documented their children's later reaction to the immunization, including redness, hardness, or swelling at the immunization site; reactions to touching the injection site or moving the injected limb; use of pain medicine; fever or irritability; and any other suspected reactions.

***Continued on page 4***

# Vaccines for Children Program

Despite a small group of concerned parents who believe vaccines may contribute to childhood conditions such as autism, it's clear that vaccines have changed the landscape of pediatric medicine and have prevented many thousands of children from contracting diseases. For most families, children's routine immunizations are covered by their health insurance.

Those who are uninsured, or whose insurance doesn't cover vaccines, may end up not having their children immunized. Their children are at an increased risk of developing otherwise preventable diseases. Not only does contracting one of these disease affect the child and his family, but it also increases the burden on already taxed healthcare system (more doctor's visits and hospitalizations, for example).

Fortunately, the Vaccines for Children program (VFC) helps minimize the number of U.S. children who remain unvaccinated. Passed in 1994 as a response to a measles outbreak that infected thousands of U.S. children and claimed hundreds of lives, the VFC is a federally funded entitlement program that grants free routine immunizations to eligible children.

Children who are un- or under-insured, who are enrolled in Medicaid, or who are Alaskan or Native American are eligible. In most cases, the immunization is free but the doctor's office or health facility that offers the vaccine may charge an administrative fee. Most administrative fees are less than $15 per vaccine.

For more information on the Vaccines for Children program, please visit: http://www.cdc.gov/nip/vfc/Parent/parent_home.htm.

**How Important Are Vaccines?**

| Disease | # Cases Before Vaccine | # Cases Since Vaccine |
|---|---|---|
| Paralytic polio | 13,000-20,000 annually | None in W. Hemisphere |
| Hib meningitis | 600 deaths/year in children <5 | <10 deaths/year |
| Whooping cough | 9,000 deaths/year | 57 deaths from 1990-1996 |
| Rubella (German measles) | Epidemic of 20,000 cases in 1964-65 | 6 in 2000 |
| Diphtheria | 206,000 cases/year in 1921 | 2 in 2001 |
| Mumps | 212,000 cases in 1964 | 266 in 2001 |

# Measuring Bullying and Victimization in Elementary Schools

In a recent joint study between Lucile Packard Children's Hospital and the Stanford University School of Medicine, published in the April 2007 *Journal of Developmental & Behavioral Pediatrics*, lead researcher Dr. Tom P. Tarshis and his colleague Dr. Lynne Huffman concluded that there is now a valid pyschometric tool available to school psychologists and those who work with children to measure bullying and victimization among elementary school children.

In 2004, Tarshis administered the Peer Interactions in Primary School (PIPS) Questionnaire, which he helped develop, to 270 students in third through sixth grade at several elementary schools. The results of the questionnaire were not necessarily surprising, as they validated what was already believed: victimization and bullying are widespread in elementary school-aged children.

Almost 90% of the students responded that they had been a victim of bullying, and almost 60% of students reported that they had been bullies themselves. The study concluded that the PIPS Questionnaire is the first reliable and valid measurement tool for self-reported bullying and victimization and can hopefully be used in intervention programs.

*Journal of Developmental & Behavioral Pediatrics*, 4/07

# New Research Suggests that Breastfeeding Babies for at Least Six Months is Best

*By Natalie Staats Reiss, PhD*

We know that "breast is best," but what is the bottom line for nursing mothers? What length of time provides maximum health benefits for infants? The American Academy of Pediatrics (AAP) recommends that breastfeeding continue for at least twelve months. But not all women are able or willing to reach the twelve-month goal. According to the International Lactation Consultant Association (ILCA), approximately 70% of women in the United States breastfeed alone or in combination with formula at the time of hospital discharge. The rate drops to about 33% at six months, with even lower rates for low-income and African-American families.

Parenting guides and books suggest that breastfeeding longer is better. Doctors tell mothers that breastfeeding for a few weeks is better than not breastfeeding at all. But how long is long enough? In 2001, the World Health Organization (WHO) changed its recommendation from exclusive breastfeeding for four to six months of age to exclusive breast feeding for at least six months. The term "exclusive breast feeding" means exactly that: the infant receives only breastmilk. No supplemental formula, water, other liquids or solid foods are provided. Of course, vitamins, minerals or necessary medicines are included in this guideline.

Even after the WHO released its recommendation, there was still some lingering debate and confusion regarding the optimal length of breastfeeding. This confusion arose in part from the lack of information about the comparative health gains of different breastfeeding time frames. Most research studies were not specifically designed to clarify whether breastfeeding for three versus four or even six months really mattered.

## Breastfeeding Duration Is Important

New findings support growing evidence that the length of time is important. The WHO recommendation is correct – six months seems to be the magic number. Researchers from the University of Califonia-Davis Children's Hospital, the University of Rochester and the American Academy of Pediatrics Center for Child Health Research studied a nationally representative sample of 2,277 babies.

These scientists compared five groups of infants. The first group included formula-only babies. The other groups of infants were fully breastfed (using formula on a less-than-daily basis) for different lengths of time: less than one month, one to four months, four to less than six months and six months or more. Infants fully breastfed for six months or more were less likely to suffer from pneumonia, ear infections, and colds than infants breastfed for four months. These health gains continued throughout the infants' second year.

Researchers in 2003 reached similar conclusions regarding breastfeeding duration effects. They compared the benefits of three and six months of exclusive breastfeeding in a sample of 3,483 infants. Babies exclusively breastfed for six months had a lower risk of developing gastrointestinal infections. In addition, exclusive breastfeeding did not cause any negative side effects such as iron deficiency during the first year of life.

## Additional Benefits

These two recent studies complement the large body of evidence indicating that breastfeeding has important benefits for children, mothers, and society. Besides protection from upper respiratory and gastrointestinal effects, the benefits of breastfeeding for infants include:

- Fewer infectious and non-infectious diseases
- Reduced risk for chronic diseases such as diabetes, cancer, allergies and asthma
- Reduced likelihood of becoming overweight and obese children
- Lower incidence of skin disorders

Mothers who breastfeed also experience positive health effects such as less postpartum bleeding, an earlier return to pre-pregnancy weight, and a reduced risk of ovarian and pre-menopausal breast cancers. Families with breastfed infants save thousands of dollars on formula and medical care. Society benefits, too. Fewer trips to physicians and hospitals reduce overall healthcare expenditures. Reduced rates of absenteeism and increased morale can translate into huge savings for large corporations as well as small businesses.

## Breastfeeding Barriers

Given the overwhelming amount of research pointing to the benefits of breastfeeding, why do only one-third of American women continue to nurse their infants for six months? Certain characteristics are associated with breastfeeding. Women who fully breastfeed tend to be older and more educated. Mothers who smoke, are single and do not participate in childbirth education classes are less likely to exclusively breastfeed.

The most commonly reported reasons for bottlefeeding are:

- A father's negative attitude toward breastfeeding
- Uncertainty regarding how much breastmilk is consumed by the nursing infant
- Return to work

Other factors influencing rates of breastfeeding include:

- Negative attitudes of healthcare professionals
- Ready availability of formula
- Nipple pain and irritation
- Time constraints
- Embarrassment
- Lack of confidence
- Concerns about dietary or health practices

Mothers indicate that receiving more information from prenatal classes, TV, magazines, and books would increase the likelihood of initiating and maintaining breastfeeding. According to lactation specialist Charlotte Burnett, BSN IBCLC from Truman Medical Center Lakewood (Kansas City, MO), much of the educational process targets dispelling common myths about breastfeeding. For example, many women believe that they are completely unable to eat beans, spicy foods, chocolate, junk food or drink soda while breastfeeding. Other women "seem to think they should not even start to breastfeed if they are planning on returning to work or school in six weeks," says Burnett.

Obtaining more family support would also help increase rates of breastfeeding. If a mother or sister didn't or couldn't breastfeed, a new mother may have less confidence and desire to breastfeed, reports Burnett. Even if a mother chooses to nurse, detrimental family comments can undermine this decision. Burnett's clients have heard comments such as, "Just give him a little real milk" or "She wants to breastfeed so much. Are you sure you shouldn't just give her a bottle?"

To complement education and family support, the International Lactation Consultant Association states that supportive, breastfeeding-friendly communities are imperative to increase national rates of breastfeeding. This may be one of the most difficult hurdles to overcome. "A huge barrier is the free formula that companies give away. We are trying to change a culture," reports Patricia Lindsey-Salvo, a lactation specialist who runs the Breastfeeding Center at Beth Israel Medical Center in Manhattan.

In 2001, the Department of Health and Human Services released a "Blueprint for Action on Breastfeeding" as part of the Healthy People 2010 initiative. This document detailed a comprehensive national breastfeeding policy with a goal of increasing the number of new mothers who breastfeed to 75%. The document also calls for expanding the proportion of women breastfeeding at six months to fifty percent, and twenty-five percent at twelve months.

## So What Should a Mother Do?

So what does all of this research and information mean for a mother? Get as much information as you can before deciding to breast or bottle-feed. Discuss problems or concerns that are likely to affect your breastfeeding goals with a lactation consultant or sympathetic pediatrician. Share information with your family and friends, and surround yourself with encouraging and supportive voices. Nurse your infant as long as possible, aiming for at least six months. "The evidence is rolling in every day about the benefits of breastfeeding," reports Lindsey-Salvo.

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***Bigger Needles Are Better, continued from***

Sixty-one percent of the infants had some type of reaction at the injection site. The infants in the wide, long needle group had fewer injection site reactions than either of the other two groups. There was no difference among the three groups in systemic reactions – fever, irritability, etc.

The researchers conclude that using the wider, longer needles are preferred. They postulate that wide, long needles help the vaccine more consistently reach the muscle, which results in a lower injection site reaction rate.

*British Medical Journal*, 9/16/06

# Does Watching Television Affect School Performance?

*By Iman Sharif, MD, MPH*

Many researchers have looked at the effect of television on school performance; however, most of the research has been done in preschool children. Researchers have come to different conclusions, depending on what they analyzed. Two main areas of research are "screen time" (how many hours a day kids watch television) and "content" (what, exactly, they watch). One study that followed children over many years found that girls who watched more hours of television when they were preschoolers ended up with worse grades during high school; on the other hand, boys who watched more television ended up with better grades. When they looked at content, the researchers found that girls (but not boys) who watched violent shows as preschoolers ended up with worse grades in high school; but for both girls and boys, kids who watched educational programs as preschoolers ended up with better grades in high school.

Few studies have looked at the effects of television viewing on older kids. Recently, several studies have shown that for both elementary school and middle school children, kids who watch more television get worse grades in school. We recently published a study that looked at more than 4,500 middle school students living in the Northeastern United States. Children completed a paper and pencil survey that included questions about how much television they watched, what they were allowed to watch, and how well they were doing in school. Here's what we found: 1) Kids who watched more television on weekdays (but not weekends) did worse in school; and 2) Kids who said their parents let them watch R-rated movies did worse in school. The effect of watching R-rated movies was especially true for boys.

The findings from our study suggest a couple of important pathways for how television affects school performance. First, since "screen time" was only an issue on weekdays, it suggests that kids who watch more television are not spending enough time on their homework or studying for tests. This doesn't come as a surprise. But it is important to have the information so that parents can negotiate more reasonably with their kids. We didn't find that watching television was all bad… just watching too much television (more than one hour) on weekdays had a detrimental effect on their school performance. Watching more television on weekends didn't seem to hurt their performance until kids watched more than three hours a day, which suggests that parents can reasonably relax television rules a little on weekends.

The other main finding, that being allowed to watch R-rated movies was associated with worse school performance, suggests that parents should really monitor what their kids watch – even in middle school. Boys who were allowed to watch R-rated movies even "once in a while" were 60% more likely to do worse in school. It is important to remember that our study does not answer the question of whether or not kids who do badly in school are more likely to choose to watch R-rated movies, or whether it is watching R-rated movies that results in worse grades. We also don't know what, exactly, the kids were watching that made the movies R-rated.

On the other hand, many other researchers have found a relationship between watching violence on television and more "acting out" or behavior problems, which can lead to worse school performance. We think that the reason R-rated movies had a greater impact on boys is probably that boys picked more violent R-rated movies to watch, whereas girls may have watched more romance movies, etc.

Because our study was cross-sectional (we asked about television watching and school performance all at the same time), we cannot say that watching television causes worse school performance. It could be that kids who do worse in school watch more television and more R-rated movies. But, either way, we believe it is important for parents to know that there is an association. In spite of the limitations of research to date, we believe that our findings so far support the American Academy of Pediatrics' recommendation that children watch no more than two hours of quality television programming a day. Our data suggest that parents should also limit their children's viewing of R-rated movies.

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# Children in Hospitals

*By John E. Monaco, MD*

## Managing Kids' Pain in Hospitals

Parents hate for their children to feel pain. This is a biologic fact. How many of us have felt that it would be easier to experience pain ourselves than to watch our children go through it? I have heard parents say the following sorts of things time and time again: "If only I could go through this instead of them." Or, "I wish they could transfer their pain to me." Needless to say, considerable anxiety surrounds this issue, and in terms of medical management of kids in hospitals, the treatment of pain and related matters can be one of our greatest challenges.

It is up to us caregivers to first determine if pain exists. This may sound insensitive, but many times children exhibit anxiety not just because of pain, but also because of other issues such as separation, loss of control or something that "feels like" pain, such as muscle spasm. Also, many children, especially toddlers, express extreme anxiety with medical procedures such as IVs and even vital sign checking, whether or not they cause true "pain." In these cases, judicious sedation, or even more sophisticated behavioral techniques, may be indicated.

Most of the time, pain is fairly easily identified. Certainly, the teenager who comes to the hospital with a compound fracture of the femur is in terrific pain. Important to recognize, however, is that the muscles surrounding this huge bone are most likely in spasm, as a result of the pain and trauma of the actual injury. Adequate treatment would involve a narcotic agent, like morphine, which is the gold standard for pure pain management. Also, a muscle relaxant, like a Valium-type drug, can be extremely helpful. I have found in these cases that if muscle spasm is treated effectively, fewer narcotics are required. In other words, it is often helpful to approach pain from multiple directions in order to treat it effectively.

We try to instruct parents and older patients about the "pain cycle" in situations like this. There is more to pain than just the actual sensation. The anticipation that pain will occur can sometimes produce as much anxiety as the pain itself. Every parent, as well as any patient in the hospital who has experienced pain, will tell you that one of the worst periods of time is that from when the nurse call button is pressed, and the request for pain medicine is made, until the medicine actually arrives. It can seem like an eternity.

The famous scene from the movie *Terms of Endearment* where the mother (played by Shirley MacLaine) begs hysterically for pain medicine for her daughter with cancer, played by Debra Winger, is a very accurate depiction of the extreme anxiety that is created when pain treatment is delayed. Their anxiety holds over until the next time the pain inevitably returns. Knowing the treatment will probably be delayed, the patient then experiences even greater anxiety, making the perception of pain even more acute. The cycle quickly becomes a vicious one, and can only be broken when the patient knows her pain will be effectively treated, or preferably prevented.

One strategy to interrupt this cycle is the so-called PCA, or patient controlled analgesia. A wonderful little pump delivers narcotic when the patient feels the need to control the pain. It is designed so that when she presses a button, narcotic is released in tiny dosages until pain is relieved, thus rendering the patient in control of her own pain management. The machine can be set for a maximum dose within an hour, and have multiple dosage controls to insure safety.

Interestingly, when a patient feels in control of her pain, her actual need for pain medicine is reduced. The pain cycle is thus broken. Obviously, this device is not appropriate for small children, but most school-age kids, depending on their level of sophistication, can use these very effectively. Parents should never be designated to push the "button;" it must always be up to the child to control. The only case of narcotic overdose I have seen with a PCA pump is when a parent kept pushing the button long after the child's pain relief had been achieved.

Children's fear and anxiety surrounding their hospitalization are just as important and potentially disabling as actual pain. Children's hospitals are cognizant of this fact, and entire departments are often dedicated to

alleviating anxiety in hospitalized children. Art, music, pets and theater have all been used to take the edge off the hospital experience.

In our institution we have had great success with what we call our Conscious Sedation for Procedures program. It is designed both for inpatients as well as outpatients for various procedures such as MRIs, CAT scans, EEGs, echocardiograms and even studies like bone scans, upper GI exams and VCUG exams. Our goal is to complete the procedure, which is often impossible if the child is anxious or fearful and thus unable to lay still. Drugs like thiopental, pentobarbital, benzodiazepines and narcotics in appropriate combinations have made it possible to successfully complete necessary tests with minimum anxiety and few side effects. We have had particular success with rectal-administered thiopental, which we have found to be very safe and effective for most procedures. Although giving a medication rectally can sometimes represent an indignity in and of itself, obviating the need for an IV can result in a huge reduction in anxiety.

The goal with hospitalized children is to minimize pain, anxiety and fear as much as possible. Often this requires medications; occasionally agents to reduce muscle spasm and anxiety are necessary. It is always true however, that compassion and an understanding of the complex nature of pain perception in kids must be utilized in order to optimize the hospital experience.

*John E. Monaco, MD, is board certified in both Pediatrics and Pediatric Critical Care. His new book,* Moondance to Eternity*, is now available. He lives and works in Tampa, Florida. He welcomes your comments, suggestions, and thoughts on his observations.*

# Backyard Playground Safety

*By Vikki Sloviter*

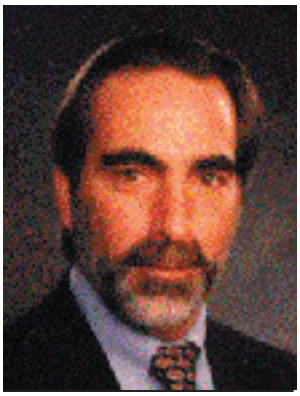
What are some well-known harbingers of Spring? Flowering trees, sounds of bees, cool iced teas, scrapes on knees. That's right: with warm weather comes much anticipated outdoor playtime, when children can throw off the coats and boots and spend hours hanging upside down on the monkey bars and swinging on swingsets until the sun goes down.

While public playgrounds (including school playgrounds) must adhere to strict playground regulations that dictate the height of monkey bars and the depth of absorbent ground covering, backyard playgrounds are much harder to regulate. According to the National Estimate Injury Surveillance System (NEISS), an online database sponsored by the Consumer Products Safety Commission, there were nearly 80,000 monkey bars and other playground equipment-related emergency room visits in 2006.

While families often do not have the means to purchase commercial-grade structures or materials that would make their backyard playspaces as safe as commercial ones, there are recommendations they can follow to make their backyard play structures as safe as possible. Here are a few key ones to follow:

- Since most injuries result from falling from playground equipment, make sure you have protective surfacing: shock-absorbent ground material. For equipment up to seven feet high, you should have nine inches of wood chips, mulch or shredded rubber.
- Install protective surfacing at least six feet in all directions beyond the footprint of the play equipment. If you have swings, the surfacing should extend to twice the height of the suspending bar (i.e. if the suspending bar is 6 feet high, the surfacing around the swings should extend to 12 feet in all directions around the swing).
- Do not attach loose ropes (pet leashes, jump ropes, clotheslines, etc.) to any playground equipment because children can become enstrangled.
- Spaces between guardrails and ladder rungs should be less than 3.5 inches or more than nine (9) inches wide so they don't pose an entrapment hazard.
- Any platform or ramp that is more than 30 inches off the ground should have a guardrail to prevent children from falling.
- Regularly check the equipment for loose, sharp or broken parts.
- Always supervise your child.

For more information on public and backyard playground safety, visit www.cpsc.gov.



# Perspectives on Parenting

*By Michael K. Meyerhoff, EdD*

## Emotional Intelligence

We have a tendency to consider cognition and emotion as two entirely separate entities. Thinking is one thing, feeling is something else, and each is entirely independent of the other. We either react with our heads or we react with our hearts.

The fact is that the way we feel is heavily dependent on the way we think. Yes, events and situations cause us to experience the kind of physiological responses we associate with emotion. But it ultimately is up to our brains to make sense of what is happening and decide precisely what it is we are experiencing. Consequently, not everyone has the same emotional response to the same event or situation. And some of us react in a manner that is more pleasant and productive than others.

The capacity to react in a healthy manner is what is referred to as emotional intelligence. And obviously, people with a higher level of emotional intelligence fare a lot better, both personally and professionally, in life. Consequently, one of the more important parts of parenting is helping your child to develop the kind of cognition that will allow him to effectively regulate his emotions.

Now this is not something you have to worry about during the first two or three years of life. Infants and toddlers are not really "thinkers" and thus are only capable of what are referred to as the basic emotions – joy, sadness, fear, and anger. They respond to events and situations in a natural and virtually universal fashion without anyone having to teach them the appropriate way to respond. In this regard babies in Japan are practically identical to babies in New Jersey.

Between two and three years of age, children become "thinkers" and become steadily more capable of the more complex emotions such as shame, embarrassment, jealousy, pride, etc. An 18-month-old toddler walks around with poop in his pants all the time. Is he embarrassed? Of course not. But an eight-year-old child with poop in his pants is going to be thoroughly embarrassed.

In other words, children have to learn the circumstances under which they should experience these more complex emotions. As a result, not every child will react in the same way. Consider this. Let's say you are an eight year old in New Jersey who has just received an A on a spelling test, and you find out that no other child in your class received a grade higher than C. How do you feel? Pretty proud of yourself, aren't you? Well, if you were an eight-year-old child in Japan, you would be deeply ashamed of yourself.

We live in a highly individualistic culture. Children are taught that they should do their own work and that they should rise and fall on their own merits. Japan has a much more collectivist culture. Children are taught to work as a team and that everyone should rise and fall together. Therefore, in Japan, a child who worked so hard to elevate himself but did not take the time and make the effort to help his classmates also do well would be hanging his head instead of lifting up his chin.

While the greater culture certainly plays a role in the development of complex emotions, parents should keep in mind that their ability to influence the process is enormous. Whenever you react to an event or situation, make sure you model the sort of reaction that reflects the values and attitudes you want your child to incorporate into his thinking. Monitor his reaction to various events or situations, and provide encouragement or correction as you deem appropriate. Statements from mothers and fathers such as "That's something you should be proud of" or "That's nothing to be embarrassed about" go a long way toward shaping a child's mindset in these matters and determining his level of emotional intelligence.

It is also incumbent upon parents to work on their child's basic emotions once he becomes a thinker. Again, we have a tendency to believe that events and situations will determine if we are going to be happy or sad. But the reality is that the way we process and analyze those events and situations is what ultimately will result in either joy or misery.

One key component of emotional intelligence that parents can work on with their child is something called counter-factual thinking. When something happens, we often are inclined to imagine something else that could have happened but didn't. Our evaluation of what actually happened will depend on which direction our counter-factual thinking takes us.

Say you are watching the Olympics. The 100-meter dash has concluded, and the medalists are standing on the podium. Who is the happiest person up there? The gold medalist. Second happiest? If you said the silver medalist, look again. He's as gloomy as can be. Meanwhile, the bronze medalist is almost as happy as the gold medalist. Why would the Olympian who came in third be happier than the athlete who came in second?

What is going through the mind of the silver medalist? He's thinking, "A slightly better start, a step faster, and I could have had the gold." What is going through the mind of the bronze medalist? He's thinking, "A slightly worse start, a step slower, and I could have been out of the medals entirely. All those years of training and the trip to Athens would have been a waste. At least I'm going home with an Olympic medal."

The silver medalist is imagining something that could have happened but didn't, and what he is imagining is a lot better than what actually happened. As a result, he is chagrined. The bronze medalist is imagining something that could have happened but didn't, and what he is imagining is a lot worse than what actually happened. As a result, he is elated.

Children do not automatically go in one direction or another. Consistently going in the more pleasant and productive direction when it comes to counter-factual thinking is definitely something that depends on what their parents have instructed and encouraged them to do in such circumstances.

Another key component of emotional intelligence involves social comparisons. We routinely wait to decide if something that happens is reason for glee or gloom until we find out what has happened to other people. Let's say a child gets a B on a spelling test. Is he happy or sad? Well, before he decides, he asks the other kids in the class, "What did you get?" If he learns that he was the only B and everyone else got a C or below, he is ecstatic. If he learns that he was the only B and everyone else got an A, then he is totally distraught.

Therefore, it is wise for parents to assist their children in developing healthy frames of reference in this regard. If a child is always inclined to look at people who have it better than he has, that child will be consistently sad. If a child is always inclined to look at people who are worse off than he, that child will be consistently happy. I made a point of repeatedly reminding my children and grandchildren of the story about the man who was miserable because he had no shoes…until he met a man who had no feet.

As children get older, peers, the popular media, and other factors may become increasingly influential and the power of parents to mold emotional intelligence may be diminished. Nevertheless, parents should make an effort to monitor what is going on, illuminate relevant issues, and at least make suggestions as they feel may be warranted.

For example, I regularly conduct a little exercise with my college students. I ask them, "If you won 10 million dollars in the lottery, what is the first thing you would do?" As each one replies, I make a clarifying comment as appropriate. If a student says, "I would buy a Corvette," I note, "So material things make you happy." If a student says, "I would invest it," I note, "So a sense of security makes you happy." And if a student says, "I would buy my Mom a house," I note, "So the happiness of those you love makes you happy." I'm not sure that I change their values and attitudes through this exercise, but I do know I prod them to contemplate and evaluate the criteria they use when making decisions about their emotional state.

All parents say they want their child to be happy. And most parents are eventually disappointed to discover that do not have the kind of control over events and situations that will guarantee their child's happiness. But they can take comfort in the notion that there is a lot they can do to ensure their child has the capacity to shape his thoughts in ways that will incline him to make himself happy regardless of whatever may happen.

*Michael K. Meyerhoff, Ed.D., is executive director of The Epicenter Inc., "The Education for Parenthood Information Center," a family advisory and advocacy agency located in Lindenhurst, Illinois. He may be contacted via e-mail at epicntrinc@aol.com.*

Check out the Pediatrics for Parents Podcast at iTunes or on the Pediatrics for Parents website.

# Answers to Your Questions

Our experts will answer your questions. Please keep them general in nature as we can't give specific advice nor suggest treatment for your child. All such questions should be asked of your child's doctor. Send your questions to QandA@pedsforparents.com or to Pediatrics for Parents, 120 Western Avenue, Gloucester, MA 01930.

## School Problems

**Q** My fifth grader isn't doing well in school. What are the first steps I should take to see if there is a medical problem?

**A** There are many reasons why some children don't do well in school. Often, the best way to address a problem is with input not only from your child's doctor, but also from your child's teachers, tutors, and school counselors. Sometimes, an evaluation by a psychologist with expertise in academics can help zero in on the problem and set up a plan for treatment.

Common medical problems that can contribute to poor school performance include some very simple things. Is the child getting enough quality sleep? Most school-aged children need nine hours of sleep a night, and some need even more. Children who are hard to get up on school days or who like to "sleep in" very late on weekends are not getting their sleep during the school week.

Sleep apnea, in children often caused by large tonsils and adenoids, can cause symptoms of inattention and poor focus. Likewise, children who consume caffeine from sodas (especially citrus sodas), coffee, or iced tea may not get good sleep quality. Allergies, chronic pain, or other illnesses can also interfere with a good night's sleep.

Children also need to get enough unstructured time to "run off steam." Many schools have cut back on recess, but this puts the more active kids at a disadvantage. If your child has trouble unwinding in the classroom, try to allow enough time after school for running off that extra energy.

Although good nutrition is important, there's no need for any child to take mega-doses of vitamins. These won't help in school. If your child is a picky eater, an inexpensive generic multivitamin will "fill in the gaps" and provide the nutrition that's needed. Every child should start the day with a decent breakfast to provide enough fuel for the morning.

Your child's doctor should already know if any chronic health condition or developmental disorder could affect your child's school performance. A review of your child's health history and physical exam will reveal almost all medical issues that could lead to school problems. Blood testing is very unlikely to uncover any unsuspected problems, and more advanced medical testing is almost always unnecessary. More subtle conditions, including learning disabilities and problems with language or visual processing, will need to be diagnosed by a psychologist. Likewise, if you, your pediatrician, and your child's teachers suspect attention deficit disorder (ADD), work with a psychologist to thoroughly test for this and similar disorders before beginning therapy.

*Roy Benaroch, MD*

## Lyme Disease

**Q** We are spending our vacation this summer in a wooded area and I am worried about Lyme disease. How can I prevent my two-year-old daughter from catching it?

**A** You can protect your daughter from Lyme disease by taking some simple preventive measures. First, make certain that she wears protective cover-up clothing when outdoors, especially in the woods. This means dress her in clothes that cover as much skin as possible – a hat, long sleeves, long pants tucked into socks and closed shoes. An insect repellent also can be helpful. Be careful with products containing Deet. If Deet-containing, they should have concentrations of less than 10%.

Lyme disease is transmitted by a deer tick bite. The good news is that even if your child is bitten by an infected deer tick, it takes at least 24 hours of the tick being attached to her skin for the organism to be transmitted to her. Therefore, it is very important for you to carefully examine her from top to bottom each night, checking for any ticks. If you find one and remove it properly, you have nothing to worry about, since the tick was attached for less than 24 hours and therefore no harm was done.

The proper way to remove a tick is as follows:

1) Clean the area with an alcohol sponge
2) Using forceps or tweezers, grasp the tick as close to its mouth and the person's skin as possible
3) Using gentle steady tension, pull the tick out and save it to show to your doctor

4) Clean the area thoroughly with alcohol

There are many cases of Lyme disease where there is no history of a tick bite and so those cases are more difficult to diagnose. Of course, if you suspect that your child may have Lyme disease, check with your doctor. A circular rash, headache, fever, muscle aches and pains should raise your index of suspicion. There are blood tests that can confirm the diagnosis. Antibiotic treatment started within 30 days of transmission is very effective in treating and curing this infection.

If you follow these suggestions, you can relax and enjoy your vacation without having to worry.

*Alvin N. Eden, MD*

# Medical Errors

**Q** What can I as parent do to lessen the chances my child will become the victim of a medical error?

**A** Medical care is complex, and many of the medications and procedures used by doctors can cause significant harm if an accident or mistake occurs. There are important steps every parent should take to prevent medical errors from hurting someone in your family.

*Be an active and inquisitive member of your child's healthcare team.* Ask questions and expect answers. If you don't know what's going on you're less likely to be able to spot a problem.

*Insist on clear communication.* If you don't understand instructions, ask the doctor to repeat them and write them down.

*Choose a doctor who listens and a staff that is happy.* A humble doctor doesn't mind when others help spot mistakes, and a happy staff will be more likely to speak up when something isn't right.

*Office record keeping should be clear.* Every medical record should be clear, organized, and legible. If your doctor's office is always losing paper and can't put their hands on your information right away, errors are far more prone to occur.

*Be certain that all treating physicians know every medicine your child takes.* One easy way is to bring a brown lunch bag of all of your child's prescriptions, over-the-counter medicines, and any supplements to every doctor's appointment.

*Know your child's medication allergies in detail.* You should know not only the names of any medicine that has led to a reaction, but the exact detailed history of any reaction that has occurred.

*You should be able to read every handwritten prescription.* Double check every medicine when you pick it up from the pharmacy – is it what you expected?

*Learn how to administer your child's medicines.* Liquids need to be measured; inhaled medicines sometimes need special devices and instructions. Ask your doctor or pharmacist how to give all medicines in the best way.

*Follow up on any tests.* Ask when to expect results of any test or x-ray, and call your doctor if you haven't heard the results in a reasonable amount of time.

*Insist that health care workers wash their hands.* Infections that are caught at a medical visit are a significant health problem. All health care providers should wash or sanitizer their hands before and after every encounter.

*Speak up.* If you think you've spotted a problem, bring it up with your doctor. You have a responsibility as a parent to speak up and help protect your child if something is not going right.

You can't expect your physician or medical office to never make a mistake. But by choosing a medical office that is well run, and insisting on clear communication between doctors, nurses, and patients, you can reduce the risk that a medical error will harm your child.

*Roy Benaroch, MD*

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# Online Autism Registry

Parents of children with autism can now participate in a national online research project. By signing up with the Interactive Autism Network (IAN) at www.ianproject.org, they can also be linked to local and national support groups. The organizers of the IAN hope, by that end of the year, to have "the largest collection of family-provided data ever compiled on autism spectrum disorder.

A similar database, organized decades ago, helped fight childhood leukemia. The information in the database helped researchers revolutionize the treatment of this previously almost always fatal disease.

The project is sponsored by the Kennedy Krieger Institute, Johns Hopkins University, and Austim Speaks.

*Family Practice News*, 5/1/07

# Hip Dysplasia

*By Betsy Miller*

Developmental dysplasia of the hip (DDH) – many people have never heard of it, but it is surprisingly common. Developmental dysplasia of the hip, formerly called CDH (congenital dysplasia of the hip), is believed to be the most common defect in newborn babies and accounts for 75% of all congenital defects.

Developmental dysplasia of the hip is a condition in which the ball at the top of the thigh bone (femoral head) is not in the correct position inside the hip socket. It can cause uneven leg lengths, limping, and hip clicks. It can also cause problems with the structure of the hip joint that can be seen in ultrasound or X-rays.

A baby may be born with DDH or may develop it in early life. In most cases it is only in the left hip, but both sides can be affected. Many babies are born with unstable hips that usually stabilize within the first two weeks after birth. Unstable hips are not the same as DDH. With DDH, the problem persists and requires early medical treatment.

About one in 1,000 babies have hip dysplasia. Its more common in children with the following risk factors:

- Family History: DDH tends to run in families with hip problems.
- Girls: DDH occurs in girls nine times more often than boys.
- First born, breech, or large babies: The position of the baby in the womb and crowding in the womb increase the risk.
- Left hip: Most babies lie with their left hip against the mother's spine, which limits motion of that hip. This may be why the left hip is more likely to have DDH.
- Connective tissue disorders, club foot, cerebral palsy, torticollis (limited motion on one side of the neck), and central core disease: Children with these conditions are at a higher risk of also having DDH

Make sure that your child's doctor knows about all medical conditions that your child has, and about any family history of risk factors.

Babies are examined for DDH when they are newborns and during their regular checkups. If the doctor suspects DDH, or if your baby is at risk, the American Academy of Pediatrics (AAP) recommends a hip ultrasound. Ultrasound is used for babies up to four months of age because their bones are too soft to show up well on X-rays. The ultrasound may reveal a problem that does not show up in an examination. Or it could show that the child's hips are fine.

If a hip problem is suspected, then the baby or child is seen by a pediatric orthopedic doctor. These doctors have special training to diagnose and treat orthopedic problems in babies and children. Developmental dysplasia of the hip cases range from mild to severe, but the goal of treatment is always the same – to get the femoral head into the best position in the hip socket so that the hip joint can develop normally. The pediatric orthopedic doctor chooses the best treatment for each child. Treatment may include a Pavlik Harness, a brace, or in severe cases, surgery and a cast. Each of these treatments is described below.

## Pavlik Harness

If DDH is caught very early, the Pavlik harness is effective 90% of the time. This soft brace keeps the baby's legs apart and at the ideal angle in the hip sockets to encourage proper hip development.

The doctor may wait until the baby is six to eight weeks old to see if the hips stabilize on their own. If not, then the baby is fitted with a Pavlik harness. The baby may need to wear the harness 24 hours a day. The doctor adjusts the harness as the baby grows. For six weeks the doctor examines the baby's hips, and uses ultrasound or X-rays to see how the hip joints are developing. If the baby's hips improve, then this treatment is continued as needed until the baby is up to six months old. If the hips do not improve, then the doctor removes the harness and tries a different treatment.

Many children are finished with treatment after the Pavlik harness is removed and only need follow-up checkups. Others need to wear a brace (hip abduction orthosis), or may need surgery.

## Brace (Hip Abduction Orthosis)

Children six months of age or older may wear a brace, also called a hip abduction orthosis, as treatment for DDH. A variety of braces are used. Most come in several sizes. The pediatric orthopedic doctor selects the brace. It may be worn 24 hours a day, or for a shorter period of time. The doctor examines the child's hip and uses X-rays to see how the hip joints are developing. If the hips improve, then this treatment may be continued until no longer needed, or until the child is old enough to remove the brace on her own.

## Surgery and a Cast

Though most children with DDH do not require surgery, it is needed in some cases. Surgery is done for babies and toddlers while the hip is still developing. A child may need surgery for the following reasons:

- The femoral head cannot go into the hip socket because soft tissue is blocking it.
- The baby was born with teratologic hip dysplasia.
- Other treatments have not worked.
- Developmental dysplasia of the hip was diagnosed in an older child, and the bones in the hip joint have developed in the wrong shape and need to be corrected

Some doctors use traction before surgery to relax a child's muscles and tendons so that it is easier to put the femoral head inside the hip socket.

During surgery doctors use arthrography (an X-ray with dye injected into the joint) to learn more about the structure of the joint. Then they do the least invasive procedure to correct the hip joint. Surgeries that may be needed for DDH are listed below:

- Adductor Tenotomy: A small cut is made to a tendon to allow it to stretch enough for the doctor to do a reduction.
- Closed Reduction: The doctor puts the femoral head into the hip socket without opening up the hip socket.
- Open Reduction: The doctor must surgically open the hip socket.
- Osteotomy: If the child's bone structure prevents normal hip development then the doctor may need to do a pelvic osteotomy (cutting the bone around the hip socket) or a femoral osteotomy (cutting the leg bone).

After surgery, the child wears a body cast, called a Spica cast, to hold the hips in place. The length of time that the child wears 12-16 weeks.

## If Your Child Has DDH

Caring for a baby or child who is undergoing treatment for DDH can be challenging. She may not fit into her car seat or stroller. And if your child is in a cast, then even simple daily tasks like diapering can be difficult at first. These organizations provide for support and resources for parents of children with DDH:

The hip-baby website offers information about medical treatment and practical advice for parents at: http://www.hip-baby.org.

Shriners' Hospitals offer free consultations or treatment for children diagnosed with DDH and other orthopedic problems.

Shriners Hospitals
PO Box 31356
Tampa, FL 33631
1-800-237-5055
http://www.shrinershq.org

Easter Seals can sometimes help locate car seats for children who cannot fit into a standard car seat:

Easter Seals
230 West Monroe Street, Suite 1800
Chicago, IL 60606
800-221-6827
http://www.easterseals.com/site/PageServer

*Betsy Miller is a freelance writer who has written about a wide variety of t opics from dental sealants to wireless technology. As an adult with DDH,she has a strong interest in this condition. Miller lives in Cupertino, California with her husband and two daughters.*

# Ibuprofen - An Injured Child's Best Friend

When a child is hurt, parents want to do anything to ease his pain. But often they don't know what the best course of action is, or what type of pain medication will work best. Of three well-known analgesics, acetaminophen, ibuprofen and codeine, which one, if any, is best for children? Researchers from the University of Ottawa, Ontario, recently sought to answer that question, and their finding may surprise some parents.

Eric Clark, MD of University of Ottawa and his colleagues evaluated data collected from 300 children ages 6-17 who presented to the emergency department of the Children's Hospital of Eastern Ontario between May 2002 and January 2003 for musculoskeletal injuries to their extremities, neck or back. The children were randomly assigned to one of three groups, each of which received initial oral doses of 15mg of acetaminophen, 10 mg of ibuprofen or 1 mg of codeine. The children rated their pain before they received the pain medication (baseline) and then every 30 minutes for 120 minutes using a visual analog scale (a 100 mm hatched line with "no pain" at one end and "worst pain" at the other). After the first 60 minutes and then every 30 minutes, the children were asked if they needed more pain medication. No more pain medication was administered once the children scored a 30 mm or below on the visual analog scale.

***Continued on page 14***

Though there was no statistical difference in pain relief among the three medications after only 30 minutes, 60 minutes later, the average reduction in pain on the visual analog scale was 11 points less for those who were given codeine, 12 points less for those given acetaminophen, but a whopping 24 points less for those given ibuprofen. At one and two hours past the initial administration of any one of the medicines, ibuprofen showed significant pain relief over acetaminophen and codeine in children who had experienced fractures. Interestingly, for children with soft tissue injury, there was no statistical difference in pain relief among the three medications.

There were a few limitations to the study, including the relatively small number of participants. But, the researchers claim the final study group of 336 children (300 of whose data were used for the primary outcome) was a good representation of the 780 children who were originally eligible to participate.

So, the next time your child has a musculoskeletal injury to an extremity, neck or back, a dose of ibuprofen – commonly sold as Motrin, Advil, or Nuprin, and variety of store brands – may help ease the pain.

*Pediatrics*, 03/07

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